LeadingAge Connecticut

Testimony to the Human Services Committee

Presented by Mag Morelli, President of LeadingAge Connecticut

February 11, 2015

Supporting

HB 6550, An Act Concerning Medicaid Provider Audits

Good evening Senator Moore, Representative Abercrombie, and members of the Human Services Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership organization representing mission-driven and not-for-profit provider organizations serving older adults across the continuum of long term care, services and supports and including senior housing. On behalf of LeadingAge Connecticut, I would like to submit the following testimony in support of HB 6550, *An Act Concerning Medicaid Provider Audits*, and offer the Committee our assistance to you as you consider this bill.

Fraud and abuse have no place within the health care system and should never be tolerated within the Medicaid program. As Medicaid providers, the members of LeadingAge Connecticut understand, accept and support the need to protect the integrity of the program through state oversight and audits, but we encourage efforts to ensure that the oversight and audit processes used by state government are both fair and balanced and are designed so as not to add unwarranted expense to the health care field. The goal of the state's audit program should be to promote integrity within the program, not to artificially inflate findings so as to maximize recoupments.

LeadingAge Connecticut supports the proposals contained in this bill which would bring a level of fairness to the Medicaid audit and extrapolation processes and which would require transparency, outreach and education by the Department of Social Services. If enacted, the elements of this proposal would assist in provider compliance, reduce provider error, and promote integrity within the program.

This proposal would specifically bring reforms to the audits conducted with fee for service Medicaid providers. Many of these providers are small organizations serving Medicaid clients in the community through the Connecticut Home Care Program for Elders. These are providers who are paid rates of reimbursement that are well below their costs of providing the services. To add insult to injury, they are subjected to audit practices that seize upon small errors which are extrapolated to large findings that are beyond the ability of these small providers to pay. Many are forced to engage expensive legal counsel in an attempt to reduce the inflated amount demanded by the state. It is forcing good, quality providers to consider leaving the Medicaid system.

We are pleased to be joined by our colleagues in the health care field in our call for fair and reasonable Medicaid audit practices. We have attached a detailed joint statement from our coalition of associations whose members are serving and caring for those covered by the Medicaid program. While we all understand that oversight is imperative to maintaining the integrity of the Medicaid program, it should be fair and balanced and not add unnecessary costs and burdens to those providing the Medicaid services.

Thank you for this opportunity to submit this testimony.

Mag Morelli, President

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***LeadingAge Connecticut** is a membership organization representing over 130 mission-driven and not-for-profit provider organizations serving older adults across the continuum of care including nursing homes, residential care homes, housing for the elderly, continuing care retirement communities, adult day centers, home care and assisted living agencies. By continuing a tradition of mission-driven, consumer-centered management and competent, hands-on care, not-for-profits set the standard in the continuum of housing, care and services for the most vulnerable aging adults.*

Coalition of Care Providers Statement

Key Measures Necessary to Achieve Transparency in Audit Practices, Clarity for Medicaid Providers, and Fairness of the Audit Process

A coalition of care providers met in 2014 to identify key measures necessary to achieve transparency in audit practices, clarity for Medicaid providers, and fairness of the audit process. The coalition includes the Connecticut Hospital Association, the Connecticut Association for Healthcare at Home, the Connecticut Association for Health Care Facilities, the Connecticut State Medical Society, LeadingAge Connecticut, the Connecticut State Dental Association, the Connecticut Community Providers Association, the Connecticut Pharmacist Association, the CT Homemaker & Companion Association, Companions and Homemakers, CVS Health, Quest Diagnostics, the Northeast Pharmacy Service Corp., and the Connecticut Association of Community Pharmacies, Inc. The coalition's recommendations are described below.

Extrapolation

Extrapolation is a statistical technique for inferring what occurred outside the range of what was actually measured, and should not be used in the following circumstances:

1. **Across Disparate Services**: Do not extrapolate across disparate services, apply only to like claims.
2. **ED vs. Non-ED Claims**: Claims related to emergency medical care should not be extrapolated to claims not related to emergency care.
3. **Observation Care**: Claims for any appropriate medical care for anyone in observation status after 23 hours.
4. **Clerical Errors**: Circumstances involving a clerical error, especially when there was no financial impact resulting from the error.
5. **Unintentional Overlap in Services**: When two unrelated providers submit claims for serving Medicaid clients during the same time period, caused by circumstances beyond their control.

6. **Transition to New Billing Procedures**: When payment or billing errors result from a transition to a new billing procedure.
7. **Prior to Policy Effective Date**: When claims were submitted prior to the issuance of the specific audit and/or reimbursement policy that is the subject of the audit.
8. **No Notice of Service Plan Amendment**: When the provider demonstrates that it was not made aware of a plan amendment prior to providing the service.
9. **Unique or Rarely Used Claims**: Unique claims should be dealt with individually.
10. **Outlier Claims**: Outlier claims should be dealt with individually.

Sampling Methodology

Extrapolation projections must be based on a statistically valid random sample, as reviewed by a statistician or by a person with equivalent expertise in probability sampling and estimation methods.

1. **Early Disclosure of Sampling Methodology**: The methodology should be disclosed at the outset of the audit.
2. **Sample Stratification**: Claims should only be pulled that are specific to the procedure or service identified by the CPT code.
3. **Use of Median vs. Average**: The median should be applied in cases in which claims with multiple services are being extrapolated to reduce the overweighting of multiple claims.
4. **Paid Claims Only**: The universe of claims to be sampled cannot exclude claims for which no payment was issued.

Fairness of the Audit Process

These measures should be implemented to ensure the fairness of the audit process:

1. **Compliance with Federal and State Rules**: A provider should be permitted to raise, at any time, including as an item of aggrievement, that its compliance with a state or federal law or regulation explains or negates a negative finding in an audit.
2. **Additional Information to be Provided by the Auditor**: Auditors should provide the following information regarding audit activities:
    a. At the commencement of the audit:
        i. The name and contact information of the specific auditor(s);
        ii. The audit location – either on site or through record submission;
        iii. The manner by which information shall be submitted; and
        iv. The sampling methodology to be employed in the audit.
    b. When extrapolation is used, the formula and data/claims used in the sampling shall be provided to the provider and disclosed in the audit report.
3. **Auditor Qualifications**: Auditors must undergo training and possess certain qualifications:
    a. Auditors must have coding experience, including but not limited to applicable ICD, CPT, and HCPCS codes.
    b. Decisions regarding medical necessity must be made by a professional licensed in the same clinical discipline.
    c. Auditors must have general knowledge of the particular provider services under audit and the Medicaid program they are auditing.
    d. Sampling methodology must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimate methods.
4. **Composition of the Audit Team**: The team must include qualified individuals, such as medical or dental professionals experienced in treatment, billing, and coding procedures.
5. **Appeals**: The audit appeals process should include at least 2 levels: (1) the initial request for reconsideration and (2) a second level appeal to an external party.
6. **No Recoupment While Appeal is Pending**: A provider will not be subject to alleged overpayment, re-payments, or recoupment while an appeal is pending.

7. **Look-Back Period:** Expressly limit the "look-back" period for audits to claims that are not more than two years from the date the claim was filed.
8. **Timing and Frequency of Audits:** Achieve greater transparency in the scheduling and frequency of audits. The Department should complete the audit report in a timely fashion.
9. **Conference before Issuing a Preliminary Written Report:** When an extrapolated figure exceeds $200,000, a conference must be held before the auditor issues a preliminary written report.
10. **Comparison of Preliminary Audit Findings vs. Final Written Report**: Publish an annual report comparing de-identified audit findings included in preliminary written reports against those included in final audit reports.